

Provider Insider

Alabama Medicaid Bulletin

November 2002

The checkwrite schedule is as follows:

11/08/02	11/22/02	12/06/02	12/13/02	01/03/03	01/17/03	02/07/03	02/21/03
03/07/03	03/21/03	04/11/03	04/25/03	05/09/03	05/23/03	06/06/03	06/20/03

As always, the release of direct deposits and checks depends on the availability of funds.

Medicaid Issues Clarification on Filing Limit

Generally, Medicaid requires all claims to be filed within one year of the date of service; however, some programs have different claims filing time limit limitations. For example, claims for inpatient hospital services provided through Partnership Hospital Programs (PHP) must be filed by the last day of February for the previous year; i.e., claims with dates of service 10-1-01 through 9-30-2002 must be filed by 2-28-2003.

Unless a different limitation is specifically provided in your particular provider type's program chapter the Alabama Medicaid Provider Manual, then the one year from the date of service limitation is applied.

Claims more than one year old may be processed by EDS, without intervention from the Alabama Medicaid Agency, under the following circumstances:

1. Claims filed in a timely manner with Medicare or other third party payers may be processed if received by EDS within 120 days of the third party disposition date. This date must be indicated in the appropriate remarks section of the claim as specified in the claim billing instructions for each type of provider.
 - Providers should state the disposition date in the following format: "TPL-11-01-02" or "TPL-Nov. 1, 2002."
 - For TPL denied claims, a copy of the dated insurance remittance must be attached to the claim.
2. Claims for services rendered to a recipient during a retroactive eligibility period may be processed if received by EDS within one year from the date of the retroactive award.
3. Claims for services that were previously paid by Medicaid and later taken back (either at Medicaid's request or the provider's request) may be processed if received by EDS within 120 days of the recoupment. This date must be indicated in the appropriate remarks section of the claim as specified in the claim billing instructions for each type of provider.

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Pass It On!

Everyone needs to know the latest about Medicaid. Be sure to route this to:

- ☐ Office Manager
- ☐ Billing Dept.
- ☐ Medical/Clinical Professionals
- ☐ Other _____

Appropriate Billing for Patient 1st Referred and Nonreferred Services

To bill for a service that requires a Patient 1st referral, the billing provider must have a valid signed referral form in the recipient's medical record. This form should contain the PMP's number to use for billing. If a service does not require a Patient 1st referral it is not necessary to get a referral from the PMP and it is not necessary to retain a referral form in the recipient's medical record.

A list of the Patient 1st services "requiring" and "not requiring" a written signed referral is listed in the Alabama Medicaid Provider Manual in Chapter 39.

When billing for referred services the PMP name/nine digit number, and indicator must be reflected on either the HCFA-1500 (blocks 17, 17a, and 24H) by the specialty physician or on the UB-92 (block 2) if a hospital or outpatient clinic is providing the specialty services. If this field is not properly coded, Medicaid will reject the claim. (Refer to Chapters 5 and 39 of the Provider Manual for claim instructions).

If a service performed by the billing provider does not require a Patient 1st referral, do not enter the name of a referring physician and/or the nine digit PMP number on the HCFA-1500 (blocks 17 and 17a) or on the UB-92 Claim Form (block 2).

PMPs receive a monthly report listing all claims paid by Medicaid using their name and/or provider number as the referring provider. If the PMP's name and/or number are placed on the claim form even when the service did not require a referral, the claim will appear on the PMP's monthly report. If the PMP did not actually give the referral, the PMP will report back to Medicaid that their name and/or number was used on the claim without their authorization.

Documentation of Other Insurance Payments

This is a reminder that third party payments (other than Medicare) must be entered in the appropriate field on the face of the claim, even if you are submitting a paper claim with a copy of the remittance. Failure to enter the payment amount may cause your claim to deny with a 280 denial code or cause an error in Medicaid's payment to you.

All claims that show a third party payment can be submitted electronically as long as the insurance company name and contract number are entered on the claim along with the payment amount. A copy of the third party's remittance is not required when you are submitting a claim with a third party payment. However, paper claims are required when benefits are denied by a third party. In those instances, a copy of the third party remittance must accompany the claim.

Attention ASCs and Hospitals:

Effective 10/1/02, procedure code 69990, Use of Operating Microscope, will be noncovered for outpatient services.

Medicaid Tidbits

Foster Children and Patient 1st

This is a reminder that if you find a foster child who is assigned to a Patient 1st provider, please send written notification to the attention of Gloria Wright at fax number (334) 353-3856. Foster children should not be assigned to a Patient 1st provider.

Flu Season Reminder

Procedure Codes 90658 and 90659 (influenza vaccines) are covered services for eligible recipients regardless of age. Please remember to vaccinate!

Synagis Reminder

Synagis, procedure codes Z3417 – 50 mg, and Z3387 – 100 mg requires prior authorization and is a covered service from September through March.

EPSDT Reminder

Patient 1st providers and EPSDT screening providers are reminded to perform well child check-ups according to the following periodicity schedule:

1 month	12 month
2 month	15 month
4 month	18 month
6 month	24 month
9 month	and,

every year beginning on or after the child's third birthday.

Periodic Rescreen List

The above monthly report is mailed to Medicaid providers to facilitate with scheduling well child check ups (EPSDT screenings) for children who have not received a well child check up in the last twelve months. If a recipient is assigned to a patient 1st provider, the report is mailed to the recipient's current Patient 1st provider. If a recipient is not assigned to a Patient 1st provider, the report is mailed to the EPSDT screening provider that performed the recipient's last screening. The date of the last screening has been added to the report. We anticipate this will be an additional valuable asset to an already valuable tool.

New PES Software is Now Available

A new version of the Provider Electronic Submission (PES) software is now available. PES Version 1.10 is available on CD-ROM and can be downloaded from the Alabama Medicaid website (www.medicaid.state.al.us). Changes for this release include the removal of LTC census information and the addition of more EPSDT screening information on the eligibility verification transaction. This will not impact the workability of the current PES software.

You will need to fill out a request form, found on the back page of the Provider Insider newsletter, in order to receive the new version of PES on CD.

Emergency Room Billing by Providers

Physicians billing for a visit in the emergency room 99281 - 99285 or critical care 99291, should only bill one occurrence per claim. If more than one of these procedures are found, the claim will deny EOB code 104 - procedure codes 99281 - 99285 and 99291 can only be billed once on a claim.

New LTC Software to Debut in February

The Medicaid Agency Long Term Care Division has received the following revisions to the projected date of implementation of the auto approval process. Because of the number of hours of time projected by EDS to make the necessary changes and with upcoming holidays, the following dates are more feasible. We apologize for the delay but are still anticipating the successful implementation of this new process.

February 14, 2003 - Last day for providers to transmit applications into current software version.

February 17, 2003 through February 28, 2003 - Medicaid and EDS staff to provide training related to policies and new software version.

March 3, 2003 - First day of new LTC Software.

www.medicaid.state.al.us

Medicaid Issues Clarification on Filing Limit

(Continued from Page 1)

- Providers should state the disposition date in the following format: "Recouped Claim-11-01-02" or "Recouped Claim-Nov. 1, 2002."
- A copy of the Medicaid Explanation of Payment (EOP) showing the recoupment and date must be attached to the claim.

After the above time limitations have expired, the claim becomes outdated and cannot be processed by EDS. In other words, a claim is outdated at the expiration of the one year from the date of service, or 120 days from the TPL disposition, or 120 days from the recoupment disposition, or one year from the retroactive award notice; whichever date is the latest.

After the above time limitations have expired, the claim becomes outdated and cannot be processed by EDS. In other words, a claim is outdated at the expiration of the one year from the date of service, or 120 days from the TPL disposition, or 120 days from the recoupment disposition, or one year from the retroactive award notice; whichever date is the latest.

Once a claim, which was timely filed, is outdated the provider may request an administrative review from the Alabama Medicaid Agency. The deadline for requesting an administrative review is 60 days from the date the claim became outdated. See Chapter 7 of the Alabama Medicaid Provider Manual for details on administrative reviews.

Important Mailing Addresses

Pharmacy, Dental, and UB-92 claims	EDS Post Office Box 244033 Montgomery, AL 36124-4033
HCFA-1500	EDS Post Office Box 244034 Montgomery, AL 36124-4034
Inquiries, Provider Enrollment Information, Provider Relations, and Diskettes for Electronic Claims Submission (ECS)	EDS Post Office Box 244035 Montgomery, AL 36124-4035
Medicare Related Claims	EDS Post Office Box 244037 Montgomery, AL 36124-4037
Prior Authorization (to include Medical Records)	EDS Post Office Box 244036 Montgomery, AL 36124-4036
Adjustments / Refunds	EDS Post Office Box 244038 Montgomery, AL 36124-4038

REMINDER

Have You Visited The Medicaid Website Lately?

Recent updates to the HIPAA website have now been completed. The website includes a general overview of HIPAA, what the standard will accomplish and who it affects. It includes deadlines for implementation and many informative links such as, links to CMS and DHHS. Answers to frequently asked questions are included as well a link for you to email us with any questions regarding HIPAA that you may have. If you haven't visited us lately, please do so at www.medicaid.state.al.us.

How to Avoid Error 1070

A 1070 rejection is a Managed Care error that tells providers that the recipient is enrolled in the Patient 1st Program and the services require a referral from their PMP. The following individual explanations provide a quick overview of how to prevent this error from occurring.

For services performed AS A RESULT of an EPSDT screening referral

(Recipient is **NOT** enrolled in Patient 1st)

If you file hard copy claims on the HCFA-1500, you must complete the following fields:

1. Enter the name of the screening provider in block 17.
2. Enter referring EPSDT screening nine-digit provider number in block 17A.
3. Enter "1" indicating EPSDT in block 24H.

If filing electronically on the HCFA-1500 using EDS' Provider Electronic Solutions Software, you must complete the following fields:

1. Enter referring EPSDT nine-digit provider number in the "REFERRING PROV#" field.
2. Enter "E" indicating EPSDT in the "EPSDT/Family Planning" field.

For services performed AS A RESULT of an EPSDT screening referral AND a Patient 1st referral

If you file hard copy claims on the HCFA-1500, you must complete the following fields:

1. Enter the PMP's name in block 17.
2. Enter referring PMP's nine-digit provider number in block 17A.
3. Enter "4" indicating EPSDT and Managed Care in block 24H.

If filing electronically on the HCFA-1500, using EDS' Provider Electronic Solutions Software, you must complete the following fields:

1. Enter referring PMP's nine-digit provider number in "REFERRING PROV#" field.
2. Enter "B" indicating EPSDT and Managed Care in "EPSDT/Family Planning" field.

For services performed AS A RESULT of a Patient 1st referral ONLY

If you file hard copy claims on the HCFA-1500, you must complete the following fields:

1. Enter the PMP's name in block 17.
2. Enter referring PMP's nine-digit provider number in block 17A.
3. Enter "3" indicating Patient 1st in block 24H.

If filing electronically on the HCFA-1500 using EDS' Provider Electronic Solutions Software, you must complete the following fields:

1. Enter referring PMP's nine-digit provider number in the "REFERRING PROV#" field.
2. Enter "M" indicating Patient 1st in the "EPSDT/Family Planning" field.

Note to PMP Providers:

Primary Medical Providers (PMP) do not use a referral indicator or referring provider number on the claim when billing for services for your assigned recipients. The indicators mean that the claim is the **RESULT** of a referral and since you are the PMP there is not a referral involved. See page two of this Provider Insider for additional Patient 1st information.

Alabama Medicaid

In The Know

Submitting Paper Claims in the System

All claims submitted on paper will be scanned using Optical Character Recognition (OCR) technology.

The mailroom will return claims that are not appropriate for scanning.

- **All HCFA-1500 and UB-92 paper claims must be submitted using red dropout forms (Note that Dental forms are BLUE, with the same 'blue' drop out rules!).** Optical scanners will only read what is written in **black** ink. The red form and **anything written in red** will disappear leaving only the processing data. Unnecessary stamps and handwriting will slow down the process.
- **All claim forms must be originals.** Anything else, including faxed claims, will be returned.
- **All claim forms should be printed (by computer) or typed.** Handwritten claims are accepted, but may take longer to process.
- **All claim forms must be completed in dark black ink.** If the scanner cannot read the printed words because you didn't change your printer or typewriter ribbon, EDS will return the claim.

Consider the Following...

- Change your printer or typewriter ink frequently so claims print with dark black ink.
- Keep required information within designated blocks. Do not let information overlap lines or flow into other blocks. Remember that the claims are being 'read' electronically. If information appears in inappropriate blocks, it could cause the claim to pay or deny incorrectly.
- Keep handwriting to a minimum. Handwriting slows the optical scanning process causing the claim to pause for visual review! Optical Character Recognition (OCR) does not read handwriting efficiently. Handwritten claims that are determined to be illegible will be returned to the provider. **As a general rule, handwritten claims take longer to process and are therefore not recommended.**
- Do not write notes anywhere on the claim form. All critical blocks are explained in the *Alabama Medicaid Provider Manual*. Notes have **no** effect on the outcome of your claim. Each claim is processed as a new submission, so notes such as "corrected claim" or "2nd request" have no bearing on the processing of the claim.
- **All claim types may be submitted electronically!** Discuss electronic options with your provider representative.

EDS Provider Representatives

G R O U P 1



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Nurse Practitioners

Podiatrists

Chiropractors

Independent Labs

Free Standing Radiology

CRNA

EPSDT (Physicians)

Dental

Physicians

Optometric (Optometrists and Opticians)

G R O U P 2



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Rehabilitation Services

Home Bound Waiver

Therapy Services (OT, PT, ST)

Children's Specialty Clinics

Prenatal Clinics

Maternity Care

Hearing Services

Mental Health/Mental Retardation

MR/DD Waiver

Public Health

Elderly and Disabled Waiver

Home and Community Based Services

EPSDT

Family Planning

Prenatal

Preventive Education

Ambulance

FQHC

Nurse Midwives

Rural Health Clinic

Commission on Aging

DME

G R O U P 3



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Ambulatory Surgical Centers

ESWL

Home Health

Hospice

Hospital

Nursing Home

Personal Care Services

PEC

Private Duty Nursing

Renal Dialysis Facilities

Swing Bed

HIPAA Team Has Applied for a One-Year Extension

The Alabama Medicaid Health Insurance Portability and Accountability Act (HIPAA) Remediation Team is implementing the enhancements needed to comply with the Standard Transactions and Code Sets required by HIPAA. The Alabama Medicaid Agency opted to apply for the one-year extension. This extension will assist the Agency in bringing the system into compliance with specifications under HIPAA by the deadline of October 2003.

Providers, submitters and software vendors will be notified as billing instructions and submission requirements are modified. Until they are notified of the effective dates of any HIPAA-related changes, existing policy and billing requirements will remain in effect.

HIPAA Test Schedule Due in December

Test schedules for each of the HIPAA mandated transactions will be published in December. Testing on some transactions will begin on January 2, 2003. Testing availability will begin for all transactions by April 1, 2003. The 835 Health Care Payment Advice v4010 (electronic EOP) and the NCPDP 5.1 Pharmacy Claims and Reversals transactions are already in production. Please contact EDS at (334) 215-4250 to register for testing and/or transitioning to these transaction sets or register by e-mail at HIPAA@alxix.slg.eds.com.

The HIPAA Privacy Rule: What It Means to the Provider Community

The HIPAA Privacy rule, developed during the Clinton Administration and endorsed by the Bush Administration, was published in the Federal Register December 28, 2000. Following several



administrative delays, the HIPAA Privacy Rule became law on April 14, 2001. The primary focus of the HIPAA Privacy Rule is to enhance the privacy protections afforded to individual consumers at all levels of health care treatment, payment and healthcare operations. Individual privacy protections will be enhanced by requiring health

care providers, health plans and health care clearinghouses to carefully monitor the manner in which they use and disclose the protected health information (PHI) of individual healthcare consumers. At the heart of the HIPAA privacy rule is individual authorization. Further, a number of individual privacy protections, such as a right to access, amend, and receive an accounting of PHI disclosures have been instituted by the HIPAA Privacy Rule. Additionally, a host of administrative requirements have also been instituted so as to ensure that the enhanced privacy protections are monitored and enforced.

Health and Human Services Secretary, Tommy Thompson, recently released additional guidance designed to clarify and address much of the confusion surrounding interpretation of HIPAA Privacy Rule intent. The HIPAA Privacy Rule becomes effective April 14, 2003. The Department of Health and Human Services' Office of Civil Rights has been granted enforcement authority for ensuring health providers, health

plans and healthcare clearinghouses comply with the HIPAA Privacy Rule. Additional information can be found at <http://www.hhs.gov/ocr/hipaa/bkgrnd.html>.

REMINDER

The website address for the Excluded Individuals/Entities (LEIE) is:

<http://oig.hhs.gov/fraud/.exclusions.htm>

HIPAA

Provider Electronic Solutions (PES) Software Version 1.10 is Available

EDS Provider Electronic Solutions Software Version 1.10 Request Form

DATE REQUESTED: _____
PROVIDER NAME: _____
ADDRESS: _____
CITY: _____ STATE: _____ ZIP: _____
PHONE NUMBER: () _____
CONTACT NAME: _____

What version of Windows do you have on your PC?

☐ Windows 95 ☐ Windows 98 ☐ Windows NT ☐ Other _____

☐ 1 CD ROM

☐ Diskette

☐ Complete Install of PES

☐ Upgrade

Mail this request to:

EDS

P.O. Box 244035

Montgomery, AL 36124-4035

Version 1.10 of the PES software is now available. It contains the removal of LTC census information and the addition of more EPSDT screening information on the eligibility verification transaction.

There are two forms of PES software that are available to providers free of charge. The first is a complete install of PES. This form of the software should be ordered if you have never installed PES on your computer. This form contains the complete installation program including the database and base list files. **If PES already exists on your computer and you install this form of PES, you will overwrite your database and any existing list files (recipient, provider, procedure code, etc... databases).** The second form of PES should be ordered if you already have PES on your computer. This form of the software is an upgrade. Upgrades contain any improvements or additions that we have added to the earlier versions of PES. **Upgrades will not overwrite your database or list files.**

If you need a copy of version 1.10 of the PES software, please complete the above form and mail it to EDS or download it from the Medicaid website.

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